



~~PHILIP~~ ~~WISNART, MAJOR~~
~~AND ASSOCIATES, LLC~~



DATE: 8-14-06

BILLING INFORMATION

NAME: Harris Evam M
Last First Middle Initial
ADDRESS: 3720 Edenborn Ave Metairie LA 70002
Street and # Apt. City State Zip
TELEPHONE: 888 2266 457 3687
Home Work Cell

DATE OF BIRTH: 5-25-92 AGE: 14 SOC SEC #: _____
MARITAL STATUS: Single SEX: male

If client is a minor, a full-time student, and/or another party is to be billed, please complete the following:

RESPONSIBLE PARTY NAME: Kathleen and Friedrichs H. Harris, Jr
RELATIONSHIP TO CLIENT: father

BILLING ADDRESS: _____
(If Different) Street and number Apt. #.

City State Zip
TELEPHONE NUMBER: 888 2266 ; 473 9803 457 3687
Home and cell Work

I understand that I am responsible for the cost of treatment. It is my responsibility to contact my insurer to determine coverage. Our office will file claims promptly as a courtesy; however, should insurance fail to pay, I or my assigned responsible party must pay the unpaid balance.

Kathleen Harris
Client Signature

Please list all medications + mg here;

10mg po TID
600mg po TID
10mg po BID

2mg SQ qd